State of Illinois
Department of Human Services - Division of Mental Health

DISCHARGE SUMMARY/TRANSITION RECORD

Section ONE

Last Name:	First Name:	Middle:	DMH ID Number:
Eickmeier	Julia		885273

Birth Date:	Sex:	Race:	Religion	Marital Status:	Discharge Date:	Discharge Time:
4-14-1991	F	White	None	Single	Jan 25, 2019	

Admitting Address Street:	City:	State:	Zip Code:	Plng Area:
2830 4th St. #13	Peru	IL	61354	11

NOTIFICATION OF DISCHARGE/TRANSFER TO:

☒ RCP Individual ☐ REL Relative ☐ ATT Attorney ☐ PAR Parent (if minor)
☐ GRD Guardian ☐ Other - specify:

RIN Number: 110594637

INDIVIDUAL WILL BE RELEASED TO:

Name: Lasalle County Court Relationship: Jail

Individual will reside at this address:
119 W Madison St Ste 200, Ottawa, IL 61350

Facility Name: Alton Mental Health Center

Facility Number: 19

Subunit Name: C2

Subunit Number: 4678

Discharge Geo Code:	LAS 00	Discharge Type: ABS=Absolute PRE=Pre Discharge CD=Conditional Discharge (enter one)	ABS
Discharge Planning Area:	11		
Area Code Phone Number:	815-433-0774		

Hospital Contact Name:	Hospital Contact Phone:	ICD Code:
Brian Arterbridge, MSW, MPA	618-474-3885	

Primary Discharge Diagnosis:
Unspecified Schizophrenia and Other Psychotic Disorder

Other Psychiatric Diagnosis(es):
None

Medical Diagnosis(es):
Vitamin D Deficiency

Medications, Dosage and Indications for use post Discharge:
See Medication Reconciliation Form-Attached

☒ **No medications are prescribed**
☐ **Medication Instructions Given (see Section Three)**
☐ **See Medication Reconciliation Form - (attached)**

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Oct 24, 2018	10:00:00 AM	Jan 25, 2019	

If form is printed and completed by hand, add additional pages as necessary.

Section ONE - A

Advance Directives or Surrogate Decision Maker

(Plan is documented, or reason for not providing advance care plan.)

☒ Individual **has** an Advance Directive and/or Surrogate Decision Maker

- ☐ Medical Advance Directive
- ☐ Mental Health Treatment Preference

☐ Advance Directive was discussed but Individual **did not wish,** or was not able to name a Surrogate Decision Maker or Provide an Advance Care Plan.

- ☐ Medical Advance Directive
- ☐ Mental Health Treatment Preference

☐ The Individual's **cultural and/or spiritual beliefs** preclude a discussion of advance care planning as an advance directive would be viewed as harmful to the patient's beliefs and thus harmful to the physician patient relationship.

☐ Individual expressed an interest in obtaining an Advance Directive or Surrogate Decision Maker during this hospitalization. Information has been given to begin and assist with the process of obtaining an Advance Directive and/or Mental Health Treatment Preference.

For assistance with executing an Advance Directive, contact:

- *Illinois Guardianship & Advocacy Commission/Human Rights Authority*
  (866) 274-8023
- *Equip for Equality*
  (800) 537-2632

Instructions Given to Individual/Family on Discharge:

Follow up with Dr. Fields for outpatient therapy and substance abuse treatment services. Please utilize other leisure activities, coping skills and abstain from drugs and alcohol. Upon release contact the crisis hot line if she begins to have thoughts of harming or killing herself (Life Line 1-800-273-8255). To join a support group to address substance abuse. To take her discharge summary, court order indicating release to the community and discharge paperwork from jail (if discharged to jail from IDHS/ DMH) to her local social security office and public aid office to get her benefits reinstated. Individual was given these instructions and she verbalized an understanding.

Plan for follow-up care and Recommendations: (Include additional discharge arrangements not included on section 1.)

a. Additional discharge arrangements:

Follow up with your primary care physician within 3 weeks.

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Section TWO

Note: Benefits-related information is shared as a professional courtesy. It is not a guarantee of coverage. Benefit status can change rapidly. IDHS rules require providers to check each individual's Medicaid status on-line.

Indicate Individual's Funding Source (You may indicate more than one)

- ☐ Social Security/Retirement
- ☐ Medicare
- ☐ Medicaid
- ☐ GRANT/No Fee Payment
- ☐ Social Security/Disability
- ☐ VA
- ☒ Other Personal
- ☐ Supplemental Security Income
- ☐ Social Security Funds
- ☐ CHAMPUS
- ☐ DMHDD Purchase Care
- ☐ Public Aid/Other Pub Res
- ☐ Health Insurance
- ☐ None

Living Arrangement Code: ALONE

Discharge Movement: CCOURT

Referral for Services: GRANT

*Requires Home Code for Long Term Care Nursing Facility:

LLTCF Home Name: N/A

LLTCF Home Code: N/A

Did Individual have a hearing loss? Yes ☐ No ☒

If so, did Individual require a reasonable accommodation during Hospitalization? Yes ☐ No ☐ Not Applicable ☒

What, if any, accommodations are needed? (Mark all that apply)

- ☐ Sign Language Interpreter
- ☐ FM System
- ☐ Large Print Materials
- ☐ Closed Captions
- ☒ Other: N/A

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Section THREE-Detailed Narrative-continued
(Completed by Discharging Physician)

3) Hospital Course: (Treatment/Habilitation Including Medication Tried and Response, Laboratory Results, Significant Findings, Major procedures and tests performed during inpatient stay and summary of results)

a. Tobacco and Alcohol use treatment:

Tobacco: ☐ Received practical counseling for Tobacco use. ☐ Received medication for Tobacco use. ☐ Not Applicable

Alcohol: ☐ Received brief intervention for Alcohol use. ☐ Received brief counseling for Alcohol use. ☐ Not Applicable

b. Cooperation:

☐ Individual was generally cooperative during the stay. ☐ Individual was frequently uncooperative.

☐ Individual was initially uncooperative but later, cooperative. ☐ Individual was occasionally uncooperative.

☒ Individual was not cooperative.

Comment:
Ms. Eickmeier has been constantly declining the use of psychotropic medications.

c. Group Participation: Individual attended the prescribed groups with:

☒ minimal participation ☐ moderate participation ☐ active cooperation

Comment:
N/A

d. Restriction of Rights: (Episodes of restraint/seclusion, or ROR during stay)

Individual was in **Restraints:** ☒ never ☐ occasionally ☐ frequently

Individual was in **Seclusion:** ☒ never ☐ occasionally ☐ frequently

Individual received **Restriction of Rights** for:

☐ activities ☐ medications ☐ other:

Comments for Restriction of Rights Section:
N/A

e. Non Suicidal Self-Harming Behavior:

Did Individual exhibit **self-harming behavior** during Hospital stay? Yes ☐ No ☒

If yes, please describe below:
N/A

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Section THREE-Detailed Narrative-continued
(Completed by Discharging Physician)

g. Medication Adherence: (Adherence with medication and treatment)

- ☐ Individual adherence to medication was excellent.
- ☐ Court ordered medications.
- ☐ Individual initially did not agree to take medication and later agreed.
- ☒ Poor medication adherence.
- ☐ Adherence with medication was questionable.

Comments on Medication Adherence:

Ms. Eickmeier continuously declined psychotropic meds. throughout her hosp. stay.

h. Medical Issues & Procedures: (List any medical issues treated during hospitalization including major procedures performed during inpatient stay and summarize results)

- ☐ None
- ☐ List:

i. Laboratory/Tests:

- ☐ No significant abnormal laboratory/test results.
- ☒ Significant laboratory/test results.

List and Describe results:

Vitamin D Deficiency

j. Family involvement: (Family involvement during the stay)

Family involvement was: ☐ minimal ☒ some ☐ extensive family involvement

- ☐ Individual has no known family.
- ☐ Individual or Family refused involvement.
- ☐ Other: N/A

Comments on Family Involvement:

N/A

k. Other Significant Issues addressed during Hospitalization: (if any) or

Ms. Eickmeier frequently declined food offered to her, but ultimately ended up gaining unspecified amount of weight.

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Section THREE-Detailed Narrative-continued
(Completed by Discharging Physician)

a. Mental Status at the time of discharge: (continued)

Speech:

☒ Normal in rate and rhythm ☐ Hyper-verbal ☐ Paucity of Speech

☐ Other Specify:

N/A

Thought Process:

☒ Coherent, Logical and Goal-Directed ☐ Loosening of Association

☐ Flight of Ideas ☐ Confusion ☐ Disorganization

☐ Other Specify:

N/A

Delusional Thinking: (Check one)

☐ No, Delusions are **not** present.

☒ Yes, Delusions **are** present.

Describe:

Ms. Eickmeier continues to exhibit underlying delusions of persecution which at times impairs her judgement in specific areas of her psychosocial functioning. She, however, shows a fair ability to problem-solve based on available recourses.

Hallucinations: (Check all that apply)

☒ None ☐ Auditory ☐ Visual ☐ Tactile ☐ Olfactory

☐ No Evidence of Psychosis

Comments:

Ms. Eickmeier does not present easily distractible or actively responding to internal stimuli.

Suicidal ideations/plans:

☒ None

☐ Not current, but has ongoing risk - see below

Comments:

N/A

Homicidal ideations/plans:

☒ None

☐ Not current, but has ongoing risk - see below

Comments:

N/A

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Section THREE-Detailed Narrative-continued
(Completed by Discharging Physician)

a. Mental Status at the time of discharge: (continued)

Insight: ☐ Good ☐ Improved ☒ Marginal ☐ Poor

Comments regarding insight:

Although Ms. Eickmeier is adamantly in denial of having a mental illness and is unable to fully appreciate her symptoms, she is able to acknowledge her limitations.

Judgment: ☐ Good ☐ Improved ☒ Marginal ☐ Poor

Comments regarding judgement:

Although able to problem-solve at a basic level, her decision-making remains heavily influenced by her underlying delusions of persecution.

Additional comments on Mental Status:

n/a

b. Lifetime Risk Factors for suicide/violence/readmission:

Prior suicide attempts?	Yes ☐	No ☒	☐	
History of causing property damage?	Yes ☒	No ☐	☐	
History of violence against a person?	Yes ☐	No ☒	☐	
History of nonadherence with treatment?	Yes ☒	No ☐	Occasional ☐	
History of substance abuse?	Yes ☒	No ☐	Occasional ☐	

c. Proactive measures taken to reduce risk:

☒ Counseled Individual/Family about the availability of firearms and other lethal weapons.

☒ Discharged Individual with a safety plan that s/he participated in developing.

d. Problems active at the time of discharge: (Medical, Psychosocial/Behavioral)

☒ None

☐ List:

6) Studies Pending at discharge: (e.g. laboratory, radiological)

☒ None

☐ List:

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Section FOUR

Initial MEDICARE Screening:

Medicare Number:

(Please mark as many that apply);

☐ Individual has inpatient coverage (A) only

☐ Individual has outpatient (B) coverage

☐ Individual has Medicare (D) coverage (drugs and pharmaceuticals)

If yes, name of Prescription Drug Plan: _____

If no, Did s/he enroll in Medicare D while in hospital? Yes ☐ No ☒

If yes, on what date did s/he enroll? _____

Initial MEDICAID Screening:

Does s/he have any type of Medicaid? Yes ☒ No ☐

If yes to Medicaid screening, check all that apply:

☐ Full Medicaid (includes disability-related, family-related and ACA Medicaid)

☐ Spend down. Amount if applicable: $ _____

☐ Medicare Savings Plan (please choose one)

☐ QMB (pays Medicare B and D premiums, as well as all Medicare co-pays and deductibles)

☐ SLIB (pays Medicare B and D premiums)

☐ Q. I. (pays Medicare B and D premiums)

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Section FOUR

Redetermination Screening

If s/he has Medicaid Redetermination Screen:

When is the next Medicaid Redetermination date? 6/30/2019

Did Medicaid Re-determination date occur during hospital stay? Yes ☐ No ☒

If person **does not** get SNAP or DHS Cash Assistance, choose one:
(Note: For these people, FCRC/Local Office can **not** handle "Re-De")

If yes to redetermination:

(Mark only one)

☐ Redetermination was completed by uploading documents to www.medredes.hfs.illinois.gov

☐ Redetermination was mailed to: Illinois Redetermination Project, PO Box 1242, Chicago, IL 60690-1242

If person **does** get SNAP or DHS Cash Assistance in addition to Medicaid:
If yes to redetermination: Redetermination was done through the following FCRC (Local Office)

Name of FCRC: _____

FCRC Contact Name: _____

IDHS/DMH Staff who assisted: _____

If yes to Medicaid:

Complete the following if Medicaid application was approved during his/her hospitalization:

Date "un-suppression" request was sent to OCAPS: _____

Name of staff person who sent request: _____

If s/he does **NOT** have Medicaid:

Was an On-Line Medicaid Application done? Yes ☐ No ☒

If yes, date application was made: _____ Application Number: _____

Documentation Uploaded:
(Check all that apply)

☐ Proof of Residency (Court Order) ☐ Identifying Information (Face Sheet/Photo ID)

☐ Approved Representative Form

☐ Other: _____

☐ Check here if this application was for a Medicare Savings Plan (QMB, SLIB)

If on-line Medicaid Application was **NOT** done, was a mail-in Medicaid Application done? Yes ☐ No ☒

If yes, date application was mailed: _____ FCRC (DHS Office) Number: _____

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